The disability and diagnosis nexus: transgender men navigating mental health care services

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Introduction

As this edited book attests, there has been increasing recognition of the importance of attending to the intersections of disability and masculinities (e.g. Hickey-Moody 2015; Loeser 2015; Shuttleworth, Wedgwood & Wilson 2012; Wedgwood 2014; Wilson et al. 2012). However, current work in this area has almost exclusively focused on cisgender men living with disabilities (i.e., men whose gender identity accords with that normatively expected of their assigned sex), overlooking transgender men and issues of gender diversity. Taking this gap as its starting place, the present chapter asserts the inclusion of transgender men in discussions of disability and masculinities. While we are cautious of conflating masculinities with men, we believe this chapter provides an important opportunity to address the absence of transgender men in the literature on disability and masculinities.

More specifically, in this chapter we seek to examine the nexus of disability and diagnosis in the context of transgender men's experiences of mental health. In referring to a nexus between disability and diagnosis, our intent is to highlight the ways in which transgender men may often experience a competing set of demands when accessing mental health care services, demands that potentially render invisible chronic mental health concerns. The first set of demands experienced by many transgender men is to obtain a diagnosis of 'gender dysphoria' in order to access therapeutic responses such as gender affirming hormones and surgery (Burke 2011). Whilst the Standards of Care of the *World Professional Association for Transgender Healthcare* do not mandate for such

a diagnosis (WPATH 2011), it is nonetheless often required by those who prescribe hormones and/or those who will perform surgery, despite the fact that transgender people have long argued against the ways in which this requirement for diagnosis unnecessarily pathologises transgender people's lives (Stone 1991; Whittle et al. 2008).

The second set of demands that many transgender men experience is an injunction to present a particular 'positive' image of themselves as part of an assessment for 'gender dysphoria'. The presentation of such a 'positive' image, it has been suggested, arises from the history of the pathologisation of transgender people's gender, the legacy of which continues in instances where clinicians refuse to accept transgender people's own accounts of their gender (Speer & McPhillips 2013). In order to ensure support for accessing gender affirming hormones and surgeries, then, transgender people may experience an expectation to minimise any mental health concerns, and instead present an image of themselves that is intended to ensure a supportive response from clinicians. Jones (2015) suggests that this expectation to minimise mental health concerns is potentially the legacy of what she terms "flawed and misinterpreted" early research on transgender people's experiences of transition, in which it was claimed that transgender people who experience mental health concerns post surgery are proof that the option of gender affirming surgery should not be made available to transgender people.

Our concern in this chapter, then, is what falls to the wayside when clinicians are potentially focused primarily on diagnosis, and when transgender people may be primarily focused on accessing a diagnosis with knowledge of the expectations that may

be placed upon them in terms of the ways they are expected to present. Our suggestion is that in some instances *actual* mental health concerns may be overlooked because of the focus on gender issues. Importantly, our point here is not to reify the diagnosis of 'disorders'. Rather, our point is that a significant number of transgender people experience may significant mental health concerns, and that if these are overlooked due to a focus on diagnosing 'gender dysphoria', this can have a significant negative impact upon outcomes for some transgender people.

In order to further unpack the points we have briefly made above, in this chapter we focus upon the potential utility of working with the idea of mental health as a disability in the context of transgender people's lives. Whilst we are very mindful of the point we made above – namely that transgender people have rightly resisted the pathologisation of their gender – we are nonetheless concerned not to throw the baby out with the bath water. In other words, whilst we are entirely supportive of the depathologisation of services provided to transgender people, we nonetheless see the importance of recognising that for some transgender people mental health concerns may have a disabling effect.

In what follows in this chapter we first outline in greater detail the theoretical approach we take to the topic of diagnosis, disability, and transgender people's lives. We then outline the small body of research that has focused specifically on transgender people and mental health, though we note that this has at times been pathologising, and that it has failed to engage with an understanding of mental health as disability. We then proceed to

present selected findings from two projects that focused on Australian transgender men and mental health. From these findings we then turn to discuss what a disability model of transgender mental health has to offer, and conclude by calling for further research and theorising that explores the intersections of masculinities and disability in the lives of transgender men.

Theoretical Framework

In presenting our theoretical framework, it is important to clearly signal that we are bringing together two somewhat competing ideas. On the one hand, following, Almassi (2010, p. 129, original emphasis), we "seek to discuss disability less in connection to impairment than to *atypical modes of embodied functioning*". In this sense, our focus is on the disabling effects of social norms in relation to embodiment, a point we discuss in more detail below. On the other hand, our focus is very much on impairment in terms of mental health. Following writers such as Shakespeare and Watson (2002), we agree that it is important to examine the disabling effects of an ableist society, but not to minimise what it means to live with an impairment. In the context of mental health, then, we would want to be critical of, for example, the stigmatisation of people diagnosed with a mental health concern. At the same time, we would also want to acknowledge the differing ways in which people live with mental health concerns (such as 'hearing voices' approaches to schizophrenia, which celebrate voices rather than attempting to regulate them with medication). And further, we believe it is important to acknowledge that for many people mental health concerns are experienced as negative and unwanted.

In terms of understanding the disabling effects of living in the context of societies that marginalise what Almassi refers to as "atypical modes of embodied function", we draw upon the work of Riggs, Ansara and Treharne (2015) to suggest that cisgenderism – the ideology that delegitimises people's own understandings of their genders and bodies – produces disabling effects. In other words, living in societies where cisgender people are treated as the norm means that for many transgender people discrimination is a daily experience. As we suggested earlier, beyond explicit intentional discrimination are the disabling effects of the requirement of diagnosis. Indeed, Riggs, Ansara and Treharne explicitly suggest that their understanding of cisgenderism draws upon a critical disability studies critique of the imposition of diagnostic categories onto people's lives. Finally in terms of cisgenderism, the norm of cisgender bodies means that transgender people's bodies are seen as problems requiring correction, correction that then requires authorisation from clinicians who diagnose a 'problem' (Clare 2013).

Riggs, Ansara and Treharne (2015) also note that one of the potential effects of cisgenderism is decompensation. Decompensation refers to negative outcomes that may arise when an individual can no longer compensate for a disabling context. With regard to transgender people, then, the effects of cisgenderism can lead to the high rates of mental health concerns amongst transgender people as compared to cisgender people (rates that we explore in more detail in the following section). Yet as we noted earlier, what falls to the wayside when we focus solely on the relationship between cisgenderism and decompensation in the form of impaired mental health are the mental health concerns that some transgender people may experience over and above the effects of cisgenderism.

We are course mindful of the fact that the individual and the context they live in are inseparable, and we are not *per se* suggesting that it would be possible to usefully or productively disaggregate certain 'causes' of impaired mental health. Nonetheless, it is potentially clinically important to be able to discern differences in the histories of certain mental health concerns for some transgender people. This is important, we suggest, as whilst for some people the effects of cisgenderism may be ameliorated by access to therapeutic responses (including timely and affordable access to gender affirming hormones and surgery if desired), for other people this will not be the case. Furthermore, if some transgender people experience an injunction to present a particular 'positive' narrative about their mental health in order to access services, then again what disappears from the picture are potentially chronic mental health concerns that exceed those arising from the effects of cisgenderism.

All of these points in regards to the disabling effects of cisgenderism and the importance of diagnosis in regards to mental health concerns for some transgender people suggests to us the utility of disability as a framework for understanding transgender people's experiences of mental health. In suggesting this, we are of course mindful, as is Puar (2014, p. 77), that

> Historically and contemporaneously, the nexus of disability and trans has been fraught, especially for trans bodies that may resist alliances with people with disabilities in no small part because of long struggles against

stigmatization and pathologization that may be reinvoked through such affiliations.

Nonetheless, and following Baril (2015), we believe it is vitally important to engage in an intersectional analysis of the relationship between trans studies and disability studies. Puar (2014, p. 80) herself prefers "assemblages" as a mode of analysis over 'intersectionality', and we certainly agree with her injunction to consider not "What is disability? And What is trans?" but rather "What does disability do? What does trans do?". For our purposes within this chapter, our interest is both in what occurs for transgender men living at the intersections of mental health impairment and gender transition in terms of clinical services, but more broadly to ask 'What does disability do?' in the context of transgender men's lives, and how might it be seen as a useful tool, rather than seeing it as always already pathologising and marginalising.

This emphasis upon the importance of asking 'What does disability do?' is highlighted, we thus suggest, by the relationship between diagnosis and disability in the lives of some transgender people. As Baril (2015) notes, for those transgender people living with impaired mental health, the ability to perform certain normatively accepted modes of masculinity or femininity – including those expected by some clinicians – may be limited to the point that support is not forthcoming. Whilst, as we explore in the following section, the question of 'differential diagnosis' is often used to implicitly frame being transgender as a mental health concern (a question that we suggest below is highly problematic), it is nonetheless important to think about how clinicians' views about

mental health concerns may both prevent them from giving support to some transgender people, whilst at the same time a focus on 'differential diagnosis' that aims to 'correctly diagnose' gender dysphoria may overlook actual mental health concerns. Before turning to look at how this occurred for some of our participants, we first briefly outline previous literature on transgender people and mental health diagnoses.

Previous Research on Transgender People and Mental Health

Riggs, Ansara and Treharne (2015) summarise the majority of the available Australian research on transgender people and mental health, and suggest that whilst transgender women in general experience poorer mental health than do transgender men, the rates of poor mental health amongst transgender men are still significantly higher than amongst cisgender men. For example, one study they review shows that a 'major depressive disorder' was indicated in 40.9% of participants assigned male at birth compared to 21.3% of participants assigned female at birth (Couch et al. 2007). While there were significant differences between the two cohorts, data using the same assessment tool with a general population sample found that a much lower percentage (6.8%) showed indicators for depression (Goldney et al. 2000). Rather than repeating Riggs, Ansara and Treharne's (2015) summary of previous research here, we first briefly explore some of the potential factors for why transgender men may fare better than transgender women in terms of mental health, before then summarising selected research on transgender people and mental health diagnoses beyond depression and anxiety.

In regards to the consistent finding that transgender men fare better than transgender women, it has been suggested that this may partly be the product of differing expectations about gender placed upon people assigned female at birth compared to people assigned male (Riggs & Due 2013a). More specifically, it has been suggested that people who are assigned male at birth are likely to face much harsher and violent discrimination when disclosing a transgender identity than people assigned female at birth (Riggs & Due 2013a). In regards to protective factors, Rotondi et al. (2011) draw on findings from the Canadian Trans PULSE Project to suggest that transgender men are more likely than transgender women to experience high levels of sexual satisfaction, and that this is related to lower levels of depression, making it a strong protective factor.

Beyond depression and anxiety, other research has argued that the prevalence rates of Autism Spectrum Disorders (ASD) amongst transgender people are higher than amongst the general population. A Dutch study of transgender children and adolescents, for example, found that the incidence of ASD was 6.4% amongst children and 9.4% amongst adolescents, which is ten times higher than the general population (de Vries et al. 2010). A study in Glasgow similarly found that 11.4% of a sample of 26 transgender participants had higher Autism Spectrum Quotients (AQ) than would be expected amongst the general population. Amongst this sample, transgender men had higher median scores on the AQ than transgender women (Smith 2014). Finally, it has been suggested that transgender people may experience higher rates of schizophrenia and schizophrenia-like personality traits than the general population (Rajkumar 2014). Gender differences in rates of schizophrenia have been found in some studies, such as an Irish study which

found that transgender women are more likely than transgender men to experience schizophrenia (Judge et al. 2014).

While the above sources suggest poorer mental health amongst transgender people as compared to cisgender people, such a focus on diagnosis rates is often pathologising and medicalising and does not necessarily allow the space to conceptualise disabling mental health issues as separate to gender identity issues. This is especially true in the repeated use of the clinical terms 'differential diagnosis' and 'comorbidity' (e.g., Eden, Wylie & Watson 2012). This type of language, we would suggest, treats transgender people's gender as a pathology to be discerned from other mental health issues, a concern that was evident in the findings we present below.

Method

Projects and Participants

The data analysed in this chapter were derived from two surveys with Australian people who were assigned female at birth but who do not identify as female. The first survey was a mixed methods study focusing on the healthcare experiences of this population (n=79). Selected quantitative findings from this survey have been reported elsewhere (Riggs & Due 2013a; b), but for the purposes of this chapter responses to three open-ended questions about experiences with counselors, psychologists, and psychiatrists were extracted for additional analysis. Specifically, we focused on responses from the 28

participants (35%) who identified as male and who reported that they had previously been diagnosed with a mental health concern. Of these participants, 17 reported that the diagnosis was depression, 6 reported that the diagnosis was anxiety, and 5 reported that the diagnosis was bipolar disorder.

The second source of data was a qualitative survey (n=18) intended as a follow up to the first survey outlined above. For the purposes of this chapter we examined responses to two questions included in the survey: "Could you share some of the key experiences you have had with healthcare professionals in terms of your gender identity?" and "Are there any additional things that you wish healthcare providers knew to better support you?". In terms of this survey, just under half of the participants (n=8) reported negative experiences with mental health professionals, and less than half of the participants (n=7) made suggestions about additional knowledge that professionals should have in order to provide support, specifically with regard to mental health concerns.

As noted above, all of the participants in the sub-sample analysed in this chapter self-identified as male. We are thus aware that the findings we report and issues we raise may not hold true for other people who were assigned female at birth and who identify with a non-binary gender, and indeed may not hold true for transgender women. Nonetheless, our logic in presenting just this sub-sample is to consider what might be needed into the future in terms of further exploring the relationships between masculinities, disability, and mental health in regards to transgender men, given we know that men and women have differing experiences of mental health (Rosenfield & Mouzon 2012).

Analytic Approach

For the purposes of this chapter, extracts were identified from both surveys that highlighted the potentially negative impact of mental health professionals either pathologising a transgender identity or failing to engage with mental health concerns. Our intent in doing so was not to over emphasise the negatives *per se*, nor to over emphasise mental health concerns amongst the samples more broadly. Rather, our point was to take up the issues we have already raised in this chapter, namely how the collapsing of a transgender identity into mental health fails to see the actual mental health concerns that some transgender people may experience. More broadly, the analysis we present of selected extracts highlights what it would mean to think about both disabling social contexts and mental health as an impairment *concurrently*, a point we then explore in more detail in the conclusion.

Results

Our analysis of the corpus of data outlined above identified three different ways in which participants spoke about the interactions between mental health concerns, gender, and service responses. We now present a representative selection of extracts from the broader corpus of extracts.

Failing to see mental health concerns

The extracts included in this first analytic section are drawn from a group of 20 men who made comments to the effect that clinicians often focused solely on gender issues, at the expense of focusing on mental health concerns

> I wish the GPs/psychologists/psychiatrists asked the difficult questions. When I saw all of them I highlighted certain facts and minimised others in order get the GID diagnosis, which meant that my mental health issues weren't addressed.

> I have seen 3 psychiatrists, 2 of whom were not very helpful in treating mental health issues other than diagnosing me as trans.

> The first psychiatrist I saw did nothing for me, never addressed my mental health issues at all, just focused on my gender.

The comments included in the first extract highlight how some transgender men may feel the need to present a particular 'positive' image of themselves in order to receive support. Whilst it could be suggested that this resulted in the clinicians not addressing the participant's mental health concerns, we would suggest that the assessment of any individual by a mental health professional should be holistic, and capable of taking into account a range of factors. With regard to the other two extracts, and as indicative of a

repeated theme that ran through participant responses, was the idea that focusing on 'diagnosis' in regards to gender meant that clinicians failed to see mental health concerns.

Failing to acknowledge impact of cisgenderism

Almost a third of the men (n=10) included in the analysis indicated that clinicians had failed to understand the impact of cisgenderism upon their mental health. In these responses there was a consistent pairing of mental health concerns with factors such as 'difficulties', 'discrimination', and 'stress':

> I applied to access my superannuation (based on disability, and specifically mental health) and the health professional who assessed my application didn't appreciate the difficulties of sex affirmation in the context that I live.

> I needed to see a psychologist to assist with depression through transition. I was diagnosed with depression when I was young and it often comes back during transitional periods of my life. The psych struggled to understand that what I was going through in terms of how discrimination was affecting my life.

> I saw a psych for anxiety and depression due to the stress of being stealth [i.e., not disclosing transgender status to others], yet they couldn't understand why it was so stressful for me.

Whilst these men did not explicitly orient to cisgenderism, we would nonetheless suggest that what is being referred to in these extracts are the stressors of cisgenderism for which many transgender people must compensate, and that for these men there is an indication that a key issue in their presentation of mental health concerns was decompensation. That the clinicians could not perceive the negative impact of cisgenderism potentially served to add to the lack of recognition and understanding that the men already experienced.

Failing to see gender concerns

A small number of men (n=5) indicated that they felt their clinicians had overlooked their gender concerns, instead focusing solely on mental health concerns. Whilst different to our focus in the opening sections of this chapter, this type of experience highlights the importance of clinicians being able to discern between mental health concerns, and other issues that may cumulatively impact upon people:

> I have struggled significantly with my mental health. At one point during a heavy bout of depression I was hospitalised and when I offered hints as to my dysphoria the doctors and nurses glanced over it, just wanting to get me on medication for the depression.

Whilst for this participant medication may have been one necessary part of the clinical response, also needed, it would appear, was a response to their experience of dysphoria. Failing to address how this person's sense of dysphoria may have contributed to their

mental health concerns thus potentially compounded, rather than addressed, the presenting issue.

Discussion

The findings presented above highlight the nexus of disability and diagnosis in the lives of two samples of transgender men. Specifically, the findings suggest that clinicians 1) over emphasise gender issues at the expense of mental health concerns, 2) fail to take into account the effects of cisgenderism, and 3) over emphasise mental health concerns at the expense of gender issues. The nexus of disability and diagnosis, then, at least in the experiences of these participants, represents a lacunae in clinical practice in Australia in terms of attending to how chronic mental health concerns amongst some transgender men may require specific, targeted, responses from clinicians.

Sinnott (2015) suggests as much in her account of what it means to engage clinically with transgender clients. She suggests that clinicians must be cautious when accepting a referral for a client who wants both assessment in terms of accessing gender affirming hormones and/or surgery, in addition to therapy. Sinnott suggests that whilst it is possible for one clinician to undertake both roles (i.e., assessment and therapy), there is something of a conflict between assessment (which in and of itself is not therapeutic, even if what it authorises may be), and the provision of therapy. Our findings would appear to suggest that for at least some of our participants, being treated by clinicians whose primary role it was to assess and prescribe may have resulted in a failure by such clinicians to also

consider that additional therapeutic responses were required. Similarly, some participants appeared to have accessed mental health professionals in order to engage in therapy, only to be met with some form of assessment.

Moving beyond the specifics of clinical responses, we can return to our earlier discussion about the utility of a disability framework in thinking about mental health and transgender men, in light of our findings. Whilst, as Puar (2014) notes, there may be considerable resistance amongst transgender communities to the language of disability, Strassburger (2012) nonetheless suggests that the logic of disability – in which discrimination on the basis of impairment may be seen as authorising legal and clinical responses – may be advantageous to some transgender people. As Strassburger suggests, whilst claims to gender identity or sex may be limited by whether or not an individual is seen as meeting the requirements of a very limited number of gender or sex categories, disability laws (and clinical responses derived from them) are based on the assumption of mutability, meaning that responses are dependent on individual need, not necessarily on adherence to a particular narrow set of categories. Strassburger (2012, p. 354) provides the following example as evidence for this claim:

> An antidiscrimination framework would fail a transwoman [sic] attempting to secure medical coverage for a trachea shave, for example, if the health insurer did not cover trachea shaves for any other population. However, under an accommodation framework, a trachea shave could be seen as a necessary body modification that could improve a transperson's [sic]

> mental health or employability. If the trachea shave were regarded as a health-improving treatment, health insurers would have to pay for it, just as they pay for durable medical equipment for those who need it and not for those without a medically necessary reason for it.

Whilst Strassburger suggests that these types of arguments work best for people who have received a 'diagnosis' of gender dysphoria, they are certainly not limited to this population of people. Instead, the assumption of mutability on which disability law and practice works accepts that what might count as an impairment or a disabling situation is subject to change, and hence someone who may require access to, for example, mental health services due to the decompensatory effects of cisgenderism may not always require such services: the application of disability as the framing concept may be time-limited.

In regards to the disabling effects of cisgenderism, Strassburger (2012) further suggests that disability laws and practice may be utilised to respond to instances of cisgenderism. In other words, under scrutiny would not be the transgender person, but rather the disabling contexts, institutions, or individuals who are complicit with the production of an impairment (e.g., mental health concerns). This type of focus, Strassburger argues, shifts the focus entirely away from a medicalised and pathologising 'diagnosis' of the individual, and instead focuses on diagnosing discriminatory social contexts. This type of focus would constitute a radical shift in terms of how the needs of transgender people are responded to.

Jack (2012) similarly makes a point about how clinicians engage with transgender people who have been diagnosed as being on the autism spectrum. As Jack suggests, for this population of people support in accessing gender affirming services may be mediated by whether or not the individual is assessed as both 'competent' and as needing of services. Jack suggests that the assessment of transgender people often relies upon assumptions of neurotypicality, which can function to exclude transgender people who are on the spectrum. Shifting away from 'differential diagnosis', and towards identifying how normative assumptions operate to exclude certain groups of transgender people from services, would thus also constitute a radical shift in terms of how the needs of transgender people are responded to.

To conclude, in this chapter we have mapped out the beginnings of an understanding of what it might mean to think about transgender people's experiences of mental health within the framework of disability, specifically with application to the lives of transgender men. In so doing we have explored the nexus of disability and diagnosis, and have suggested that what often disappears when clinicians focus solely or primarily on gender issues are the potentially chronic mental health concerns experienced by some transgender men, concerns that may be both the product of cisgenderism, and the product of other factors beyond living in cisgenderist societies.

What is required next is research that looks more closely at how a disability framework may be usefully applied to the lives of transgender men, how this may improve clinical responses, and ultimately how it may be used to combat cisgenderism. As we suggested

earlier, such research may consider how masculinities factor into transgender men's experiences of mental health, an area that has received very little attention in previous research. Whilst it is likely the case that for many transgender people mental health concerns may be ameliorated by more adequate clinical responses, there are likely to remain a considerable subset of people for whom ongoing access to mental health services is required. Responding to this need through a framework of disability, we have argued, need not reinforce pathologising understandings of transgender people's lives. Rather, it may engender focus upon the unique mental health issues that many transgender people face, and the specific responses that they require.

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